



POST-TRAUMATIC STRESS DISORDER (PTSD)

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PTSD

- PTSD is a psychiatric disorder triggered by exposure to a traumatic event such as combat, violent crime, or a natural disaster.
- PTSD symptoms include flashbacks, angry outbursts, emotional numbness, and recurring nightmares.
- Symptoms usually appear soon after the traumatic event but in some cases may not appear until months or years later.
- PTSD can cause clinical impairment in significant areas of functioning.

QUESTION

What is PTSD? What are the symptoms, diagnoses, and treatment for PTSD?

SUMMARY

The definition of PTSD has been revised several times over the years. But the Diagnostic Statistical Manual (DSM), which provides standard criteria for the classification and diagnosis of mental disorders by mental health professionals in the United States, classifies it under trauma- and stress-related disorders in its most recent edition, DSM-5, 2013.

PTSD stems from exposure to a traumatic event, such as combat, violent crime, torture, sexual violence, or a natural or man-made disaster, that caused or threatened to cause death or serious injury. It can affect those who (1) personally experience or witness the event; (2) learn that the event happened to a close relative or friend; or (3) experience repeated or extreme exposure to unpleasant or gruesome details of the traumatic event, such as first responders

collecting human remains in the aftermath of a disaster (DSM-5, 2013 p. 271).

The typical symptoms associated with PTSD vary, but they include (1) recurring recollections of the traumatic event ("flashbacks"); (2) intense psychological or physiological reaction to cues symbolizing aspects of the event; (3) persistent display of negative emotions (such as fear, anger, guilt, or shame); (4) persistent inability to experience positive emotions (such as happiness, satisfaction, or love); (5) markedly diminished interest in participating in significant activities; (6) angry,

reckless, and self-destructive behavior; and (7) avoidance of thoughts or situations reminiscent of the trauma. The symptoms may start soon after the triggering event or may be delayed for months or years after exposure to the event (delayed expression). To be characterized as PTSD, the symptoms must last for more than one month and cause significant impairment in a person's ability to function. And they cannot be attributable to the physiological effects of a medical condition or substance, such as alcohol. (Separate diagnostic criteria included in DSM for children under age six are not discussed in this report.)

Not everyone who experiences trauma suffers from PTSD. Some research suggests that temperament and genetic makeup have some bearing on the chances of developing PTSD, and it is more likely to affect people with certain predisposing conditions such as depression. But it has also been diagnosed in people with no predisposing conditions. And it can affect people of any age. Research indicates that PTSD rates are higher among veterans and others whose work increases the risk of traumatic exposure (such as police, firefighters, and emergency medical personnel.) Highest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat, and captivity and ethnically or politically motivated internment and genocide. Higher PTSD rates have also been reported among U.S. Latinos, African Americans, and American Indians than Caucasians, and lower rates among Asian Americans, after adjusting for traumatic exposure and demographic variables (DSM-5, p. 276). Events most commonly associated with PTSD in women are rape and sexual violence. In men, the event is combat exposure.

According to the literature, the main types of treatment for PTSD are psychotherapy (counseling), medication, or a combination of both.

The diagnosis of PTSD has its critics. One 2007 study, for example, describes it as a "faddish postulate" that "has redefined and overextended the reach of a long-recognized natural human reaction of fear, anxiety, and conditioned emotional reactions to shocks and traumas." The study authors conclude that "the concept of PTSD has moved the mental health field away from, rather than towards, a better understanding of the natural psychological responses to trauma" ([McHugh, P.R. and Treisman G., "PTSD: a problematic diagnostic category," *Journal of Anxiety Disorders* 21\(2\): 211-22](#)). The authors of a 2008 study concluded that the disorder's "core assumptions and hypothesized mechanisms lack compelling or consistent empirical support" ([Rosen G. M. and Lilienfeld S. O., "Posttraumatic stress disorder: An empirical evaluation of core assumptions," *Clinical Psychology Review* 28:837-68](#)).

WHAT IS PTSD?

The definition of PTSD has been revised several times over the years. Historically linked to combat veterans, and once labelled as “combat fatigue,” “battle fatigue,” or “shell shock,” PTSD is increasingly being diagnosed in civilians.

DSM is the standard classification of mental disorders used by mental health professionals in the United States. It contains a list of standard diagnostic criteria for the classification of psychiatric disorders. DSM-IV classified PTSD as an anxiety disorder. DSM-5, the current edition, classifies it with trauma and stress-related disorders. The change in classification from an anxiety- to a stress-related disorder means PTSD is no longer treated as an anxiety related to mental illness but a disorder connected to an external event.

PTSD is a mental disorder that follows exposure to an extremely traumatic or life-threatening event. These include:

1. exposure to war as a combatant or civilian;
2. incarceration as a prisoner of war;
3. torture;
4. threatened or actual sexual violence, including rape or sexual abuse;
5. threatened or actual physical assault, such as robbery, childhood physical abuse, or the Sandy Hook Elementary School shooting;
6. man-made disasters, such as a factory explosion, and natural disasters, such as the recent Washington mudslide;
7. severe motor vehicle accidents; and
8. certain medical incidents, such as waking during surgery, or a medical catastrophe involving one’s child (although a life-threatening illness or debilitating medical condition is not necessarily considered a traumatic event).

Regardless of its trigger, PTSD causes clinically significant impairment in an individual’s social interactions, capacity to work, and other important areas of functioning, which is not caused by another medical condition, medication, drugs, or alcohol.

HOW IS PTSD DIAGNOSED?

DSM-5 identifies eight criteria for mental health professionals to use in diagnosing PTSD in anyone over age six: (1) exposure to a traumatic event, (2) four clusters of symptoms (Criteria B through E), (3) duration of the symptoms, (4) how the symptoms impact one’s ability to function, and (5) whether the symptoms are

caused by substance abuse or another medical condition. To be characterized as PTSD, the symptoms must have started or been significantly exacerbated after exposure to the traumatic event. (The diagnostic criteria for children under age six are not discussed in this report.)

Exposure to Traumatic Event

The exposure to trauma may result from an individual:

1. directly experiencing or personally witnessing the traumatic event;
2. learning that the event involved a close family member or close friend and, in the case of actual or threatened death, was either violent or accidental; or
3. experiencing first-hand repeated or extreme exposure to distasteful or gruesome details of the traumatic event, such as first responders collecting body parts, or professionals repeatedly exposed to details of child abuse. (Indirect non-professional exposure through the electronic media or television such as televised images of the 9/11 attacks, photographs, or movies, unless work-related, do not qualify.)

Symptoms

The essential feature of PTSD is the development of characteristic symptoms following exposure to a traumatic event (id. at p. 274). These symptoms usually start within three months after exposure, but may be delayed for months or years before criteria for the diagnosis are met. They also may come and go over time.

DSM-5 classifies PTSD symptoms into four clusters: intrusion, avoidance, negative alterations in thoughts and mood, and arousal.

Intrusive Recollections. The traumatic event is relived in one of several ways:

1. recurring, involuntary, and intrusive distressing memories of the traumatic event;
2. nightmares related to the event;
3. "flashbacks" (feeling or behaving like the event is happening again), which can be triggered by images, sounds, smells, or feelings; and
4. intense or prolonged psychological distress, or marked physiological reactions when exposed to cues that symbolize or resemble some aspect of the event (such as hearing firecrackers or gun shots).

Avoidance of Reminders. Stimuli associated with the event are persistently avoided, including situations, people, memories, thoughts, conversations, places, or activities that trigger memories of the traumatic event.

Negative Thoughts and Feelings. Negative changes in thought and mood associated with the event begin or worsen after the event. These negative changes can take various forms including:

1. an inability to recall key aspects of the event (amnesia) unrelated to head injury or other external source;
2. persistent and exaggerated negative beliefs about or expectations of self, others, or the world;
3. persistent, distorted ideas about what caused the event or its consequences, causing the person to blame him or herself or others;
4. a persistent negative emotional state (such as fear, horror, guilt, or shame);
5. a markedly diminished interest or participation in significant activities;
6. feelings of detachment or estrangement from others; or
7. persistent inability to experience positive emotions, such as happiness, satisfaction, or love.

Arousal. PTSD is also characterized by marked changes in arousal and responsiveness associated with, and beginning with or worsening after, the traumatic event, as evidenced by two of the following:

1. irritability and unprovoked anger, typically expressed as aggressive behavior toward people or objects (for example, yelling at people or getting into fights);
2. reckless or self-destructive behavior, such as dangerous driving, suicidal behavior, unsafe sex, and excessive drug or alcohol use;
3. being constantly tense and on guard ("hypervigilance");
4. being easily startled ("exaggerated startle response");
5. difficulty concentrating; or
6. difficulty falling or staying asleep.

In addition to the above symptoms, some PTSD sufferers may also experience feelings of detachment from mind, body, or both ("depersonalization"); recurring feelings that their surroundings are unreal or dreamlike ("derealization"); or both.

The clinical presentation of PTSD varies, depending on such factors as age of onset, type and intensity of the trauma, duration and frequency of exposure, and proximity in time and place to the trauma, among other things. For example, in

some individuals, emotional and behavioral symptoms may be dominant, while in others negative arousal or negative behaviors may be most prominent (id. at p. 274). Also, symptoms may recur and worsen in response to new trauma or reminders of the original trauma.

Individuals with PTSD are 80% more likely to have symptoms that meet diagnostic criteria for at least one other mental disorder such as depression, anxiety, or substance abuse (id. at p. 280).

Other Criteria

The remaining three criteria for a PTSD diagnosis are: the symptoms (1) last for more than one month; (2) cause clinically significant distress or impairment of social, occupational, or other important areas of functioning; and (3) are not attributable to the physiological effects of a substance, such as medication or alcohol, or to another medical condition.

PREVALENCE RATES

Approximately 8.7% of people in the United States will likely develop PTSD in their lifetime, with the lifetime occurrence (prevalence) in combat veterans ranging from 10% to 30%. Somewhat higher rates of this disorder have been found to occur in U.S. African Americans, Hispanics, and Native Americans compared to Caucasians.

Anyone can develop PTSD at any age, including childhood. But women, perhaps because of greater likelihood of exposure to traumatic events such as rape and interpersonal violence, are more likely than men to develop PTSD, and women in the general population experience PTSD for a longer time than men. About 10% of women develop PTSD sometime in their lives compared to 5% of men (National Center for PTSD—<http://ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp>)

PTSD rates are higher among veterans and others whose work increases the risk of traumatic exposure (such as police, firefighters, and emergency medical personnel.) Highest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity and ethnically or politically motivated internment and genocide (DSM-5 at p. 276).

TREATMENT AND RECOVERY

According to the literature, the main types of treatment for PTSD are psychotherapy (counseling), medication, or a combination of both.

According to DSM-5, duration of PTSD symptoms varies, with complete recovery occurring in approximately 50% of adults diagnosed with PTSD within three months of the traumatic event, but some individuals remain symptomatic for longer than 12 months and sometimes for more than 50 years (id. at p. 277).

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